

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 009967	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 09/25/2015
NAME OF PROVIDER OR SUPPLIER RIVERPOINTE SURGERY CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 500 ARCADE AVE STE 100 ELKHART, IN 46514		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	<p>INITIAL COMMENTS</p> <p>AAAHC Surveyor: 33212 Facility Number: 009967</p> <p>Type of Survey: State Licensure Off Site AAAHC Accreditation Survey</p> <p>Date of AAAHC On Site Survey - ASC full survey 9/25//2015</p> <p>Date of ISDH off site review -01/27/2016</p> <p>Based on review of the 9/25/2015 AAAHC Accreditation Survey Report, it has been determined that Riverpointe Surgery Center meets the requirements for ASC Licensure in Indiana for 2015.</p>	S 000		

Indiana State Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE